FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043778

Facility Name: PAVILION OF FOREST PARK

Address: 8200 WEST ROOSEVELT (Number) FOREST PARK (City) 60130 (Zip Code)

County: COOK

Telephone Number: (708) 488-9850 **Fax #** (708) 488-9870

IDPA ID Number: 364186094001

Date of Initial License for Current Owners: 03/18/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) EDWARD N. SLACK, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	232	Skilled (SNF)	232	84,680	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	232	TOTALS	232	84,680	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,913	1,620	6,983	22,516	8
9	SNF/PED					9
10	ICF	29,247	6,108	42	35,397	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,160	7,728	7,025	57,913	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.39%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 03/23/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/23/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 27 and days of care provided 6637

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	231,441	29,983	16,528	277,952		277,952	(15,796)	262,156			1
2	Food Purchase		200,322		200,322	(7,957)	192,365	9,267	201,632			2
3	Housekeeping	159,843	36,960		196,803		196,803	(2,793)	194,010			3
4	Laundry	71,975	16,131		88,106		88,106		88,106			4
5	Heat and Other Utilities			299,225	299,225		299,225	(6,214)	293,011			5
6	Maintenance	78,300		159,608	237,908		237,908	(8,103)	229,805			6
7	Other (specify):*							2,382	2,382			7
8	**TOTAL General Services**	541,559	283,396	475,361	1,300,316	(7,957)	1,292,359	(21,257)	1,271,102			8
	B. Health Care and Programs											
9	Medical Director			49,500	49,500		49,500		49,500			9
10	Nursing and Medical Records	2,981,479	163,003	159,137	3,303,619		3,303,619	4,727	3,308,346			10
10a	Therapy	87,742	3,124	45,137	136,003		136,003	(30,930)	105,073			10a
11	Activities	108,831	11,628	19,631	140,090		140,090	(1,958)	138,132			11
12	Social Services	67,888		11,073	78,961		78,961	(9,114)	69,847			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							13,002	13,002			15
16	**TOTAL Health Care and Programs**	3,245,940	177,755	284,478	3,708,173		3,708,173	(24,273)	3,683,900			16
	C. General Administration											
17	Administrative	30,747		86,767	117,514		117,514	43,631	161,145			17
18	Directors Fees											18
19	Professional Services			416,032	416,032	(23,185)	392,847	(336,110)	56,737			19
20	Dues, Fees, Subscriptions & Promotions			102,455	102,455		102,455	(46,658)	55,797			20
21	Clerical & General Office Expenses	134,354	30,651	182,927	347,932		347,932	(39,503)	308,429			21
22	Employee Benefits & Payroll Taxes			665,185	665,185	7,957	673,142	(39,464)	633,678			22
23	Inservice Training & Education			1,471	1,471		1,471		1,471			23
24	Travel and Seminar			3,498	3,498		3,498	878	4,376			24
25	Other Admin. Staff Transportation			10,948	10,948		10,948	(10,267)	681			25
26	Insurance-Prop.Liab.Malpractice			334,375	334,375		334,375	1,222	335,597			26
27	Other (specify):*							27,927	27,927			27
28	**TOTAL General Administration**	165,101	30,651	1,803,658	1,999,410	(15,228)	1,984,182	(398,345)	1,585,837			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,952,600	491,802	2,563,497	7,007,899	(23,185)	6,984,714	(443,875)	6,540,839			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PAVILION OF FOREST PARK #0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			34,280	34,280		34,280	711,925	746,205			30
31	Amortization of Pre-Op. & Org.			2,912	2,912		2,912	12,710	15,622			31
32	Interest			303,676	303,676		303,676	875,872	1,179,548			32
33	Real Estate Taxes			24,784	24,784	23,185	47,969	(2,933)	45,036			33
34	Rent-Facility & Grounds			1,016,160	1,016,160		1,016,160	(1,011,409)	4,751			34
35	Rent-Equipment & Vehicles			3,317	3,317		3,317	3,604	6,921			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,385,129	1,385,129	23,185	1,408,314	589,769	1,998,083			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		417,430	294,322	711,752		711,752	(37,246)	674,506			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			127,020	127,020		127,020		127,020			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		417,430	421,342	838,772		838,772	(37,246)	801,526			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,952,600	909,232	4,369,968	9,231,800		9,231,800	108,648	9,340,448			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(70)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	235,970	30		9
10	Interest and Other Investment Income	(70,720)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(264)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(120,000)	21		24
25	Fund Raising, Advertising and Promotional	(25,916)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,326)	20		28
29	Other-Attach Schedule	(96,334)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (78,660)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	187,309		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 187,309		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 108,648		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

PAVILION OF FOREST PARK

ID# 0043778

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	LLC Fee (Building Partnership)	$ (400)	20	1
2	Bank Charges (Building Partnership)	(32)	21	2
3	Jury Duty	(52)	10	3
4	Legal Fees - 1999 & 2000	(13,944)	19	4
5	Collection Expense	(1,708)	19	5
6	Theft Loss	(1,593)	21	6
7	Prior Period Adjustment/PR Checks O/S	(2,893)	10	7
8	Doctor's Office-Utilities	(8,600)	05	8
9	Doctor's Office-RE Tax	(6,395)	33	9
10	Doctor's Office-Maintenance Salary	(2,783)	06	10
11	Doctor's Office-Housekeeping	(4,594)	03	11
12	Doctor's Office-Mortgage Interest	(34,903)	32	12
13	Doctor's Office-Depreciation	(13,527)	30	13
14	Architect Fees (Building Partnership)	(4,525)	19	14
15	Education Expense (Unaccounted for expense)	(385)	24	15
16				16
17				17
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20				20
21				21
22				22
23				23
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				4,605	(8,468)		(11,933)					(15,796)	1
2	Food Purchase	(334)			(433)			10,034					9,267	2
3	Housekeeping	(4,594)			1,801								(2,793)	3
4	Laundry													4
5	Heat and Other Utilities	(8,600)			2,386								(6,214)	5
6	Maintenance	(2,783)			13,219	(18,541)		2					(8,103)	6
7	Other (specify):*				1,866			516					2,382	7
8	**TOTAL General Services**	(16,311)			23,444	(27,009)		(1,381)					(21,257)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,945)			26,976	(75,792)	68,733	94	(12,339)				4,727	10
10a	Therapy				5,378	(36,308)							(30,930)	10a
11	Activities				2,083	(4,041)							(1,958)	11
12	Social Services				1,959	(11,073)							(9,114)	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				4,628		8,374						13,002	15
16	**TOTAL Health Care and Programs**	(2,945)			41,024	(127,214)	77,107	94	(12,339)				(24,273)	16
	C. General Administration													
17	Administrative				43,386	(74,572)	74,572	245					43,631	17
18	Directors Fees													18
19	Professional Services	(20,177)	4,525		6,360	(326,865)		47					(336,110)	19
20	Fees, Subscriptions & Promotions	(27,642)	400		1,732	(21,170)		22					(46,658)	20
21	Clerical & General Office Expenses	(121,625)	32		124,428	(42,769)		431					(39,503)	21
22	Employee Benefits & Payroll Taxes					(39,464)							(39,464)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(385)			1,260			3					878	24
25	Other Admin. Staff Transportation				68	(10,830)		495					(10,267)	25
26	Insurance-Prop.Liab.Malpractice				1,222								1,222	26
27	Other (specify):*				18,861		9,066						27,927	27
28	**TOTAL General Administration**	(169,829)	4,957		197,317	(515,671)	83,638	1,243					(398,345)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(189,085)	4,957		261,785	(669,894)	160,745	(44)	(12,339)				(443,875)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	222,443	454,114		9,342					26,026			711,925	30
31	Amortization of Pre-Op. & Org.		12,710										12,710	31
32	Interest	(105,623)	965,338		9,777			8		6,372			875,872	32
33	Real Estate Taxes	(6,395)			3,462								(2,933)	33
34	Rent-Facility & Grounds		(1,016,160)		4,751								(1,011,409)	34
35	Rent-Equipment & Vehicles				3,578			26					3,604	35
36	Other (specify):*													36
37	TOTAL Ownership	110,425	416,002		30,910			34		32,398			589,769	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(4,846)		(32,400)			(37,246)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers							(4,846)		(32,400)			(37,246)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(78,660)	420,959		292,695	(669,894)	160,745	(4,856)	(12,339)	(2)			108,648	45

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Forest Park Property LLC		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Expense	$ 1,016,160	Forest Park Property, LLC	100.00%	$	$ (1,016,160)	1
2	V	32	Interest Expense		Forest Park Property, LLC	100.00%	965,338	965,338	2
3	V	31	Amortization		Forest Park Property, LLC	100.00%	12,710	12,710	3
4	V	30	Depreciation		Forest Park Property, LLC	100.00%	454,114	454,114	4
5	V	21	Bank Charges		Forest Park Property, LLC	100.00%	32	32	5
6	V	19	Architect Fees		Forest Park Property, LLC	100.00%	4,525	4,525	6
7	V	20	LLC Fee		Forest Park Property, LLC	100.00%	400	400	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,016,160			$ 1,437,119	$ * 420,959	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 83,051	$ 83,051	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	83,051				(83,051)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 83,051			$ 83,051	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS, INC.	100.00%	$ 4,605	$ 4,605	15
16	V	2	FOOD				(433)	(433)	16
17	V	3	HOUSEKEEPING				1,801	1,801	17
18	V	5	UTILITIES				2,386	2,386	18
19	V	6	REPAIRS AND MAINT.				13,219	13,219	19
20	V	7	EMP. BEN. - GEN. SERV.				1,866	1,866	20
21	V	10	NURSING				26,976	26,976	21
22	V	10A	THERAPY				5,378	5,378	22
23	V	11	ACTIVITIES				2,083	2,083	23
24	V	12	SOCIAL SERVICES				1,959	1,959	24
25	V	15	EMP. BEN. - HEALTHCARE				4,628	4,628	25
26	V	17	ADMINISTRATIVE				43,386	43,386	26
27	V	19	PROFESSIONAL FEES				6,360	6,360	27
28	V	20	DUES, SUBSCRIPTIONS				1,732	1,732	28
29	V	21	CLERICAL AND GENERAL				124,428	124,428	29
30	V	24	SEMINARS				1,260	1,260	30
31	V	25	AUTO EXPENSE				68	68	31
32	V	26	INSURANCE				1,222	1,222	32
33	V	27	EMP. BEN. - GEN. ADMIN.				18,861	18,861	33
34	V	30	DEPRECIATION				9,342	9,342	34
35	V	32	INTEREST				9,777	9,777	35
36	V	33	REAL ESTATE TAXES				3,462	3,462	36
37	V	34	BUILDING RENT - UNRELATED				4,751	4,751	37
38	V	35	EQUIPMENT RENTAL				3,578	3,578	38
39	Total			$			$ 292,695	$ * 292,695	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY CONS	$ 8,468	Care Centers, Inc.	100.00%	$	$ (8,468)	15
16	V	19	ACCOUNTING	15,000				(15,000)	16
17	V	19	ANCIL ADMIN FEE	27,840				(27,840)	17
18	V	19	BOOKEEPING	47,328				(47,328)	18
19	V	19	DATA PROCESSING	8,352				(8,352)	19
20	V	19	LEGAL	21,170				(21,170)	20
21	V	19	MANAGEMENT FEE	194,880				(194,880)	21
22	V	19	PROFESSIONAL FEES	12,295				(12,295)	22
23	V	20	ADVERTISING	21,170				(21,170)	23
24	V	25	REBILL BUS	10,830				(10,830)	24
25	V								25
26	V	22	HOME OFFICE PAYROLL TAX	39,464				(39,464)	26
27	V	1	REBILL. PAYROLL DIETARY						27
28	V	3	REBILL. PAYROLL HSKPNG						28
29	V	6	REBILL. PAYROLL MAINT.	18,541				(18,541)	29
30	V	10	REBILL. PAYROLL NURSING	75,792				(75,792)	30
31	V	10A	REBILL. PAYROLL THPY CONS.	36,308				(36,308)	31
32	V	11	REBILL. PAYROLL ACTIVITIES	4,041				(4,041)	32
33	V	12	REBILL. PAYROLL SOC. SERV.	11,073				(11,073)	33
34	V	17	REBILL. PAYROLL ADMIN.	74,572				(74,572)	34
35	V	21	REBILL. PAYROLL CLERICAL	42,769				(42,769)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 669,894			$	$ * (669,894)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$	CARE CENTERS, INC.	100.00%	$ 68,733	$ 68,733	15
16	V	15	EMP. BEN HEALTHCARE				8,374	8,374	16
17	V	17	ADMINISTRATIVE				74,572	74,572	17
18	V	27	EMP. BEN GEN. ADMIN.				9,066	9,066	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 160,745	$ * 160,745	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	$ 5,669	$ 5,669	15
16	V	2	FOOD				10,034	10,034	16
17	V	6	MAINTENANCE				2	2	17
18	V	7	EMP. BEN. - GEN. SERV.				516	516	18
19	V	10	NURSING				94	94	19
20	V	17	ADMINISTRATIVE				245	245	20
21	V	19	PROFESSIONAL FEES				47	47	21
22	V	20	DUES, FEES, SUB.				22	22	22
23	V	21	CLERICAL & GENERAL				431	431	23
24	V	24	SEMINARS				3	3	24
25	V	25	TRAVEL				495	495	25
26	V	32	INTEREST				8	8	26
27	V	35	RENT - EQUIPMENT & VEHICLES				26	26	27
28	V	39	ANCILLARY ENTERAL SUPPLIES				328	328	28
29	V	1	DIETARY SUPP	17,602				(17,602)	29
30	V	39	ANCILLARY SUPP	5,174				(5,174)	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 22,776			$ 17,920	$ * (4,856)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICAL SUPPLIES	$	XCEL MEDICAL SUPPLLY LLC	100.00%	$ 101,599	$ 101,599	15
16	V								16
17	V								17
18	V								18
19	V	10	MEDICAL SUPPLIES	113,938				(113,938)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 113,938			$ 101,599	$ * (12,339)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	DEPRECIATION	$	VENTLEASE LLC	100.00%	$ 26,026	$ 26,026	15
16	V	32	INTEREST				6,372	6,372	16
17	V								17
18	V								18
19	V	39	ANCILLARY EQUIP RENT	32,400				(32,400)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 32,400			$ 32,398	$ * (2)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Relative	Administrative	0.00%	See Attached	1.86	2.58%		$		1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	1.90	3.80%	Salary Alloc.	1,690	17-7	2
3	David Aronin	Owner	Administrative	0.86%	See Attached	1.90	3.80%	Salary Alloc.	3,311	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 5,001		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 83,051	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 83,051	25

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	1,522,375	33	$ 121,047	$ 120,871	57,913	$ 4,605	1
2	2	FOOD	PATIENT DAYS	1,522,375	33	(11,374)		57,913	(433)	2
3	3	HOUSEKEEPING	PATIENT DAYS	1,522,375	33	47,342	43,569	57,913	1,801	3
4	5	UTILITIES	PATIENT DAYS	1,522,375	33	62,714		57,913	2,386	4
5	6	REPAIRS AND MAINT.	PATIENT DAYS	1,522,375	33	347,481	212,397	57,913	13,219	5
6	7	EMP. BEN. - GEN. SERV.	PATIENT DAYS	1,522,375	33	49,052		57,913	1,866	6
7	10	NURSING	PATIENT DAYS	1,522,375	33	709,129	712,466	57,913	26,976	7
8	10A	THERAPY	PATIENT DAYS	1,522,375	33	141,364	140,790	57,913	5,378	8
9	11	ACTIVITIES	PATIENT DAYS	1,522,375	33	54,745	53,877	57,913	2,083	9
10	12	SOCIAL SERVICES	PATIENT DAYS	1,522,375	33	51,491	51,491	57,913	1,959	10
11	15	EMP. BEN. - HEALTHCARE	PATIENT DAYS	1,522,375	33	121,645		57,913	4,628	11
12	17	ADMINISTRATIVE	PATIENT DAYS	1,522,375	33	1,140,506	1,135,183	57,913	43,386	12
13	19	PROFESSIONAL FEES	PATIENT DAYS	1,522,375	33	167,175		57,913	6,360	13
14	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	1,522,375	33	45,541		57,913	1,732	14
15	21	CLERICAL AND GENERAL	PATIENT DAYS	1,522,375	33	3,270,885	2,869,864	57,913	124,428	15
16	24	SEMINARS	PATIENT DAYS	1,522,375	33	33,128		57,913	1,260	16
17	25	AUTO EXPENSE	PATIENT DAYS	1,522,375	33	1,780		57,913	68	17
18	26	INSURANCE	PATIENT DAYS	1,522,375	33	32,120		57,913	1,222	18
19	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	1,522,375	33	495,816		57,913	18,861	19
20	30	DEPRECIATION	PATIENT DAYS	1,522,375	33	245,564		57,913	9,342	20
21	32	INTEREST	PATIENT DAYS	1,522,375	33	257,009		57,913	9,777	21
22	33	REAL ESTATE TAXES	PATIENT DAYS	1,522,375	33	91,002		57,913	3,462	22
23	34	BUILDING RENT - UNRELATE	PATIENT DAYS	1,522,375	33	124,898		57,913	4,751	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	1,522,375	33	94,062		57,913	3,578	24
25	TOTALS					$ 7,694,122	$ 5,340,509		$ 292,695	25

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT ALLOCATION		7	384,296	384,296		68,733	1
2	15	EMP. BEN HEALTHCARE	DIRECT ALLOCATION		7	49,011			8,374	2
3	17	ADMINISTRATIVE	DIRECT ALLOCATION		27	1,367,742	1,367,742		74,572	3
4	27	EMP. BEN GEN. ADMIN.	DIRECT ALLOCATION		27	180,242			9,066	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,981,291	$ 1,752,038		$ 160,745	25

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	HEALTH SYSTEMS INC.	2,322,899	28	578,157	413,013	22,776	5,669	1
2	2	FOOD	HEALTH SYSTEMS INC.	2,322,899	28	1,023,347		22,776	10,034	2
3	6	MAINTENANCE	HEALTH SYSTEMS INC.	2,322,899	28	185		22,776	2	3
4	7	EMP. BEN. - GEN. SERV.	HEALTH SYSTEMS INC.	2,322,899	28	52,590		22,776	516	4
5	10	NURSING	HEALTH SYSTEMS INC.	2,322,899	28	9,570		22,776	94	5
6	17	ADMINISTRATIVE	HEALTH SYSTEMS INC.	2,322,899	28	25,000		22,776	245	6
7	19	PROFESSIONAL FEES	HEALTH SYSTEMS INC.	2,322,899	28	4,819		22,776	47	7
8	20	DUES, FEES, SUB.	HEALTH SYSTEMS INC.	2,322,899	28	2,196		22,776	22	8
9	21	CLERICAL & GENERAL	HEALTH SYSTEMS INC.	2,322,899	28	43,980		22,776	431	9
10	24	SEMINARS	HEALTH SYSTEMS INC.	2,322,899	28	257		22,776	3	10
11	25	TRAVEL	HEALTH SYSTEMS INC.	2,322,899	28	50,512		22,776	495	11
12	32	INTEREST	HEALTH SYSTEMS INC.	2,322,899	28	801		22,776	8	12
13	35	RENT - EQUIPMENT & VEHICI	HEALTH SYSTEMS INC.	2,322,899	28	2,624		22,776	26	13
14	39	ANCILLARY ENTERAL SUPPL	HEALTH SYSTEMS INC.	2,322,899	28	33,430		22,776	328	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,827,468	$ 413,013		$ 17,920	25

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY LLC
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-2330
Fax Number: (708)449-3236

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	DIRECT ALLOCATION			$	$		$ 101,599	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 101,599	25

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: VENTLEASE LLC
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT ALLOCATION			$	$		$ 26,026	1
2	32	INTEREST	DIRECT ALLOCATION						6,372	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 32,398	25

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Corus Bank		X	Mortgage		6/30/96	$	$ 10,276,911		Prime+1	$ 869,367	1
2	Less Allocation to Dr. Office										(34,903)	2
3												3
4												4
5												5
	Working Capital											
6	Care Centers, Inc.	X		Working Capital				4,609,479			70,353	6
7	Diawa		X	Line of Credit				3,180,744			299,715	7
8	Shareholder Loan	X		Working Capital				50,000		0.08%	3,960	8
9	TOTAL Facility Related						$	$ 18,117,134			$ 1,208,492	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(28,944)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (28,944)	14
15	TOTALS (line 9+line14)						$	$ 18,117,134			$ 1,179,548	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income						$	$			$ (70,720)	1
2	Hunter Management	X									25,627	2
3	Allocated from Care Center	X									9,777	3
4	Allocated from Ventlease LLC	X									6,372	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (28,944)	21

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 451,596	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 232,723	2
3. Under or (over) accrual (line 2 minus line 1).		$ (218,873)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 240,724	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 23,185	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ 19,458 For 19 2000 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 45,036	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998	106,522	10
1999	174,076	11
2000	229,261	12

2001 Tax Accrual-229,260 * 1.05=240,723
Opening Accrual adjusted for Non-Care Dr. Office $6,395.
Care Center Allocation - $ 3,462
Real Estate Tax refund has not been adjusted from this report as it does not pertain to a R/E tax cost setting year.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PAVILION OF FOREST PARK COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0043778

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE 847-236-1111 FAX #: 847-236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-24-100-020-0000	Long Term Care Property	$ 229,260.62	$ 229,260.62
2.			$	$
3.	Care Center Inc.	Allocation	$ 66,986.83	$ 2,548.26
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 296,247.45	$ 231,808.88

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 99,467 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Doctor's Office - 2859 Square Feet (related assets included with non-care on page 13, and espenses adjusted out on page 5)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 25,420
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 15,622
4. Dates Incurred:

Nature of Costs: Closing Costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1995	$ 400,000	1
2	CCI Allocation			2,435	2
3	TOTALS			$ 402,435	3

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9								-		-	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		11,978,803	307,192		598,047	290,855	1,168,317	68
69	Financial Statement Depreciation			5,788			(5,788)		69
70	TOTAL (lines 4 thru 69)		$ 11,978,803	$ 312,980		$ 598,047	$ 285,067	$ 1,168,317	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 11,978,803	$ 312,980		$ 598,047	$ 285,067	$ 1,168,317	1
2	LOGO DESIGN	1998	1,275			64	64	245	2
3	CABLE/WIRING	1998	3,476			174	174	667	3
4	AVIARY SET-UP	1998							4
5	CABLING	1998	2,520			126	126	473	5
6	PAINT/WALLPAPER	1998	1,603			80	80	293	6
7	ELECTRICAL RENOV	1998	695			35	35	128	7
8	CABLING	1998	4,410			221	221	810	8
9	TV CABLE	1998	6,240			312	312	1,144	9
10	SPRINKLER SYS.	1998	900			45	45	161	10
11	CABLING	1998	635			32	32	115	11
12	TV CABLE	1998	2,905			145	145	520	12
13	FENCING	1998	4,062			203	203	711	13
14	CABLING	1998	3,368			168	168	588	14
15	CABLING	1998	6,920			346	346	1,182	15
16	SIGN	1998	1,000			50	50	171	16
17	CABLING	1998	5,945			297	297	990	17
18	CABLING	1998	4,200			210	210	683	18
19	FENCING	1998	4,062			203	203	660	19
20	SIGN UPGRADE	1998	2,195			110	110	358	20
21	CABLING	1998	1,505			75	75	231	21
22	CABLING	1998	1,415			71	71	219	22
23	LANDSCAPING	1998	28,875			1,444	1,444	4,452	23
24	LANDSCAPING	1998	2,958			148	148	456	24
25	CUBICLE CURTAIN	1998	595			30	30	113	25
26	CUBICLE CURTAINS	1998	884			44	44	147	26
27	SCONCE	1998	684			34	34	113	27
28	CHANDELEIR	1998	1,089			54	54	180	28
29	LANDSCAPING	1998	2,744			137	137	502	29
30	VACUUM PUMP PIPING	1999	1,000			50	50	150	30
31	CABLING	1999	863			43	43	125	31
32	CABLING	1999	1,535			77	77	218	32
33	FIRE SYSTEM UPGRADE	1999	10,000			500	500	1,375	33
34	TOTAL (lines 1 thru 33)		$ 12,089,361	$ 312,980		$ 603,575	$ 290,595	$ 1,186,497	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 12,089,361	$ 312,980		$ 603,575	$ 290,595	$ 1,186,497	1
2	WALLPAPER	1999	885			44	44	114	2
3	DRAPES	1999	1,023			51	51	132	3
4	MOTOR	1999	3,085			154	154	385	4
5	FIRE ALARM PANEL	1999	1,436			72	72	180	5
6	PLUMBING RENOV	1999	17,865			893	893	2,158	6
7	CABLING	1999	525			26	26	63	7
8	CABLING	1999	1,000			50	50	121	8
9	CABLING	1999	1,596			80	80	187	9
10	COVE BASE	1999	1,570			79	79	184	10
11	PLUMBING RENOV	1999	676			34	34	79	11
12	OXYGEN LINES	1999	980			49	49	110	12
13	PHONE WIRING	1999	936			47	47	106	13
14	ELECTRICAL UPGRADE	1999	8,000			400	400	867	14
15	CABLING	1999	749			37	37	77	15
16	VACUUM PUMP	1999	540			27	27	79	16
17	PHONES	1999	1,320			66	66	160	17
18	SPRINKLER UPGRADE	2000	1,250			63	63	126	18
19	FIRE ALARM PANEL	2000	688			34	34	68	19
20	TELEPHONE CABLING	2000	656			33	33	66	20
21	TELEPHONE CABLING	2000	796			40	40	77	21
22	TELEPHONE CABLING	2000	1,740			87	87	160	22
23	TELEPHONE CABLING	2000	1,598			80	80	147	23
24	HVAC	2000	815			41	41	75	24
25	SINAGE	2000	514			26	26	48	25
26	CEILING MOUNT	2000	1,100			55	55	101	26
27	CEILING MOUNT	2000	859			43	43	79	27
28	PLUMBING RENOV	2000	960			48	48	84	28
29	PLUMBING RENOV	2000	1,137			57	57	100	29
30	OUTLETS	2000	1,125			56	56	93	30
31	TELEPHONE CABLING	2000	582			29	29	48	31
32	WIRING	2000	760			38	38	63	32
33	FIRE PANEL	2000	2,608			130	130	217	33
34	TOTAL (lines 1 thru 33)		$ 12,148,735	$ 312,980		$ 606,544	$ 293,564	$ 1,193,051	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 12,148,735	$ 312,980		$ 606,544	$ 293,564	$ 1,193,051	1
2	TELEPHONE CABLING	2000	703			35	35	55	2
3	TELEPHONE CABLING	2000	1,335			67	67	106	3
4	HVAC	2000	1,101			55	55	87	4
5	HEAT ELEMENT	2000	658			33	33	52	5
6	TELEPHONE CABLING	2000	1,498			75	75	106	6
7	HVAC	2000	1,418			71	71	101	7
8	TELEPHONE CABLING	2000	749			37	37	49	8
9	TELEPHONE WIRING	2000	656			33	33	41	9
10	TELEPHONE WIRING	2000	749			37	37	46	10
11	TELEPHONE WIRING	2000	592			30	30	38	11
12	PIPING - WATER HEATR	2000	2,680			134	134	168	12
13	PAINT	2000	846			42	42	53	13
14	PAINT	2000	1,460			73	73	91	14
15	VENT REPAIR	2000	587			29	29	39	15
16	VENT REPAIR	2000	658			33	33	44	16
17	BOILER REPAIR	2000	503			25	25	33	17
18	BOILER REPAIR	2000	770			39	39	52	18
19	PAINT	2001	552			28	28	28	19
20	HVAC	2001	637			32	32	32	20
21	PAINT	2001	762			38	38	38	21
22	PAINT	2001	1,460			73	73	73	22
23	HOT WATER HEATER	2001	2,656			133	133	133	23
24	DOORS	2001	3,100			155	155	155	24
25	TELEPHONE WORK	2001	1,030			52	52	52	25
26	STATION BOARD	2001	934			43	43	43	26
27	VOICE MAIL	2001	1,984			91	91	91	27
28	CABLES	2001	618			28	28	28	28
29	TRANSFORMER	2001	646			29	29	29	29
30	HEAT EXCHANGE	2001	18,593			853	853	853	30
31	HVAC	2001	598			28	28	28	31
32	HOT WATER LEAK	2001	4,819			221	221	221	32
33	TEL WORK	2001	826			34	34	34	33
34	TOTAL (lines 1 thru 33)		$ 12,204,913	$ 312,980		$ 609,230	$ 296,250	$ 1,196,050	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 12,204,913	$ 312,980		$ 609,230	$ 296,250	$ 1,196,050	1
2	HVAC	2001	646			27	27	27	2
3	HOT WATER LEAK	2001	691			29	29	29	3
4	VALVES	2001	1,210			51	51	51	4
5	FIRE ALARM PANEL	2001	654			25	25	25	5
6	STATION	2001	934			35	35	35	6
7	SUPPRESSOR	2001	1,321			50	50	50	7
8	VOICE MAIL	2001	1,984			74	74	74	8
9	TEL WORK	2001	691			23	23	23	9
10	HVAC	2001	1,351			45	45	45	10
11	HVAC	2001	619			21	21	21	11
12	WIRING	2001	1,400			47	47	47	12
13	HVAC	2001	506			15	15	15	13
14	MILLWORK	2001	625			13	13	13	14
15	ELEVATOR REPAIR	2001	1,130			47	47	47	15
16	BOILER REPAIR	2001	3,201			133	133	133	16
17	PANEL	2001	729			12	12	12	17
18	GARBAGE DISPOSAL	2001	617			10	10	10	18
19	MODULE BOARD	2001	1,983			33	33	33	19
20	INSTALL EXPENSION TN	2001	3,643			46	46	46	20
21	ELEVATOR REPAIR	2001	850			11	11	11	21
22	TELEPHONE WIRING	2001	592			8	8	8	22
23	SATELLITE INSTALLATN	2001	832			11	11	11	23
24	CONDENSOR REPAIR	2001	1,357			11	11	11	24
25	TEL WORK	2001	395			3	3	3	25
26	TEL WORK	2001	444			4	4	4	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,233,318	$ 312,980		$ 610,014	$ 297,034	$ 1,196,834	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 12,233,318	$ 312,980		$ 610,014	$ 297,034	$ 1,196,834	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,233,318	$ 312,980		$ 610,014	$ 297,034	$ 1,196,834	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 12,233,318	$ 312,980		$ 610,014	$ 297,034	$ 1,196,834	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,233,318	$ 312,980		$ 610,014	$ 297,034	$ 1,196,834	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 12,233,318	$ 312,980		$ 610,014	$ 297,034	$ 1,196,834	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,233,318	$ 312,980		$ 610,014	$ 297,034	$ 1,196,834	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 12,233,318	$ 312,980		$ 610,014	$ 297,034	$ 1,196,834	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,233,318	$ 312,980		$ 610,014	$ 297,034	$ 1,196,834	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	232		1998	1998	$ 11,806,343	$ 302,727	35	$ 590,317	$ 287,590	$ 1,147,840	4
5			1996		43,087	1,105	35	1,231	126	6,258	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Care Center Inc. Allocation			2001	123	16	20	3	(13)	3	10
11	Care Center Inc. Allocation			2000	52	1	20	3	2	5	11
12	Care Center Inc. Allocation			1999	772	20	20	39	(19)	112	12
13	Care Center Inc. Allocation			1998	318	8	20	16	8	58	13
14	Care Center Inc. Allocation			1997	4,519	80	20	249	169	1,457	14
15	Care Center Inc. Allocation			1996	4,967	66	20	262	196	1,029	15
16	Care Center Inc. Allocation-Indiana			1997	524	122	20	23	(99)	74	16
17	Care Center Inc. Allocation			1994	-	15	20	-	(15)	-	17
18	Care Center Inc. Allocation			1993	-	4	20	-	(4)	-	18
19											19
20											20
21	Forest Park, LLC - Theater			1998	78,828	2,021	20	3,941	1,920	7,663	21
22	Forest Park, LLC- Grout Work			1998	599		20	30	30	115	22
23	Forest Park, LLC-Flooring			1998	1,500		20	75	75	288	23
24	Forest Park, LLC-Plumbing			1998	2,908		20	146	146	559	24
25	Forest Park, LLC-Cabling			1998	900		20	45	45	173	25
26	Forest Park, LLC-Flooring			1998	1,350		20	68	68	261	26
27	Forest Park, LLC-Sign			1998	32,013	1,007	20	1,599	592	2,422	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,978,803	$ 307,192		$ 598,047	$ 290,817	$ 1,168,317	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,281,192	$ 167,672	$ 128,309	$ (39,363)		$ 372,292	71
72	Current Year Purchases	62,424	26,396	4,689	(21,707)		4,689	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,343,616	$ 194,068	$ 132,998	$ (61,070)		$ 376,981	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocated from CCI		2001	$ 20,835	$ 3,188	$ 3,194	$ 6	10	$ 10,279	76
77										77
78										78
79										79
80	TOTALS			$ 20,835	$ 3,188	$ 3,194	$ 6		$ 10,279	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	14,000,204	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	510,236	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	746,206	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	235,970	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	1,584,094	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	VACANT LAND - 1999	$ 55,211	$	$	86
87	DR OFFICE - 1998	527,554	13,527		87
88					88
89					89
90					90
91	TOTALS	$ 582,765	$ 13,527	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Care Center				4,751			5
6								6
7	TOTAL				$ 4,751 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 6,921 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 126,198	$		$ 126,198	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			21,286			21,286	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			146,838			146,838	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				234,971		234,971	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						182,459		182,459	13
14	TOTAL			$		$ 294,322	$ 417,430		$ 711,752	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 60,227	$ 67,254	1
2	Cash-Patient Deposits	50,648	50,648	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,066,558	2,066,558	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	69,303	69,303	6
7	Other Prepaid Expenses	10,519	10,519	7
8	Accounts Receivable (owners or related parties)	958,972	672	8
9	Other(specify): See supplemental schedule	46,047	46,047	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,262,274	$ 2,311,001	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		455,211	13
14	Buildings, at Historical Cost		12,412,725	14
15	Leasehold Improvements, at Historical Cost	241,041	280,310	15
16	Equipment, at Historical Cost	143,694	1,314,108	16
17	Accumulated Depreciation (book methods)	(81,933)	(2,260,711)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		115,447	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(25,420)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	485	485	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 303,287	$ 12,292,155	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,565,561	$ 14,603,156	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 608,377	$ 608,379	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,506	44,506	28
29	Short-Term Notes Payable	4,609,479	4,609,479	29
30	Accrued Salaries Payable	277,995	277,995	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,206	23,206	31
32	Accrued Real Estate Taxes(Sch.IX-B)	240,724	240,724	32
33	Accrued Interest Payable	14,760	14,760	33
34	Deferred Compensation	387	387	34
35	Federal and State Income Taxes	(38,400)	(38,400)	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	8,572	8,572	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,789,606	$ 5,789,608	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	50,000	13,507,655	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 50,000	$ 13,507,655	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,839,606	$ 19,297,263	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,274,045)	$ (4,694,107)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,565,561	$ 14,603,156	48

*(See instructions.)

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,846,084)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,846,084)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(427,961)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (427,961)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,274,045)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,931,327	1
2	Discounts and Allowances for all Levels	(1,866,936)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,064,391	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,478,664	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,478,664	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	70	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	41,271	16
17	Sale of Drugs	230,732	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	34,238	19
20	Radiology and X-Ray	6,440	20
21	Other Medical Services	852,705	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,165,456	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	70,720	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 70,720	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	24,608	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 24,608	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,803,839	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,300,316	31
32	Health Care	3,708,173	32
33	General Administration	1,999,410	33
	B. Capital Expense		
34	Ownership	1,385,129	34
	C. Ancillary Expense		
35	Special Cost Centers	711,752	35
36	Provider Participation Fee	127,020	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,231,800	40
41	**Income before Income Taxes (line 30 minus line 40)****	(427,961)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (427,961)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing	3,774	4,356	116,460	26.74	2
3	Registered Nurses	23,474	24,394	538,627	22.08	3
4	Licensed Practical Nurses	45,482	50,797	1,028,032	20.24	4
5	Nurse Aides & Orderlies	110,821	126,461	1,277,785	10.10	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,351	6,224	87,742	14.10	8
9	Activity Director	1,812	1,812	23,508	12.97	9
10	Activity Assistants	6,902	7,443	85,323	11.46	10
11	Social Service Workers	4,438	4,927	67,888	13.78	11
12	Dietician	1,321	1,473	17,222	11.69	12
13	Food Service Supervisor	1,926	2,174	36,080	16.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,177	23,283	178,139	7.65	15
16	Dishwashers					16
17	Maintenance Workers	4,326	4,771	78,300	16.41	17
18	Housekeepers	21,509	23,093	159,843	6.92	18
19	Laundry	9,138	10,022	71,975	7.18	19
20	Administrator					20
21	Assistant Administrator	1,468	1,652	30,747	18.61	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,261	11,261	134,354	11.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,877	2,111	20,575	9.75	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	275,057	306,254	$ 3,952,600 *	$ 12.91	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	415	$ 16,528	01-03	35
36	Medical Director	Monthly Fee	49,500	09-03	36
37	Medical Records Consultant	Monthly Fee	4,704	10-03	37
38	Nurse Consultant	160	8,449	10-03	38
39	Pharmacist Consultant	Monthly Fee	3,880	10-03	39
40	Physical Therapy Consultant	115	6,266	10a-03	40
41	Occupational Therapy Consultant	45	2,525	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	38	10a-03	43
44	Activity Consultant	59	2,820	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	CCI Cost	See attached	139,983		48
49	TOTAL (lines 35 - 48)	795	$ 234,693		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	625	$ 20,322	10-03	50
51	Licensed Practical Nurses	717	13,263	10-03	51
52	Nurse Aides	2,014	32,728	10-03	52
53	TOTAL (lines 50 - 52)	3,356	$ 66,313		53

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Administrator salaries directly allocated from HO			$
Diane Hart	Asst Admin	0	30,747
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 30,747

B. Administrative - Other

Description	Amount
Chris Wayer-Management Fee	$ 12,195
CCI Administrator Payroll-(adjusted on page 6)	74,572
TOTAL (agree to Schedule V, line 17, col. 3)	$ 86,767
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	Accounting	$ 35,140
Maxxsource	Computer	500
IIT/Sourcetech	Computer	1,686
Personnel Planner, Inc.	Unemployment Consulting	2,432
Alpha Data	Data Processing	8,582
Deutsch, Levy & Engel	RE Tax Appeal	23,185
Neal, Gerber & Eisenberg	Legal	13,341
Winston & Strawn	Legal	1,268
M Cohen	Management Consultant	1,148
Collection Fees	Various-see attached	1,707
Care Centers, Inc.	Various-see attached	327,044
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 416,032

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 148,934
Unemployment Compensation Insurance	31,938
FICA Taxes	302,271
Employee Health Insurance	131,303
Employee Meals	7,957
Illinois Municipal Retirement Fund (IMRF)*	
Pension	3,558
Misc Employee Welfare	7,717
TOTAL (agree to Schedule V, line 22, col.8)	$ 633,678

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	36,065
Health Care Worker Background Check	
(Indicate # of checks performed 125)	1,492
Yellow Page Advertising	1,326
Licenses & Fees	2,203
Dues & Subscriptions	14,083
Advertising & Promotion	47,086
Allocation Care Center Inc.	1,754
Less: Public Relations Expense	
Non-allowable advertising	(47,086)
Yellow page advertising	(1,326)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 55,797

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,498
Educational Materials	615
Allocation Care Center Inc.	1,263
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,376

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **CNA only**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL Council on LTC-$9,391**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,054** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **127,020**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **SEE PAGE 11** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **7,957** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **70**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **FR&R** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees